TRANSITIONAL CARE

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TRANSITIONAL CARE

Learning objectives:

- Understand the rising importance of transitional care
- Define transitional care and recognize several models of transitional care
- Explain the key components of transitional care
- Describe aspects of transitional care assessments and interventions
- Identify primary causes of readmissions and correlating interventions
- Learn to guide a chronic disease patient through patient engagement
- Apply learning through a case study

WHY TRANSITIONAL CARE NOW?

The Transition from Volume to Value

- In fee-for-service, the more we do, the more we get paid
- In Value based arrangements we get a fixed amount for each person
- Currently 35% of St. Luke's reimbursement is under an "at-risk" arrangement
- 5% of patients are responsible for about 50% of health care costs
- Major diagnosis that account for that 5% are : CHF, COPD, DM, CKD, Cancer
- Most of the long term success or failure for those patient depend on lifestyle factors: diet, activity, avoidance of toxins (tobacco/ETOH)

TRANSITIONAL CARE

Defined: Transitions of care are a set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.

Care transitions occur when a patient leaves one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moves to another. For example:

1. Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.
2. Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.
3. Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.
4. Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist

SOME MODELS OF TRANSITIONAL CARE

- Transitional Care Model – Naylor model
  - http://www.transitionalcare.info/
- Care Transitions Intervention Model– Coleman model
  - http://caretransitions.org/about-the-care-transitions-intervention/
- Better Outcomes for Older Adults through Safe Transitions - BOOST model
  - http://www.hospitalmedicine.org/BOOST/
- The Bridge Model
  - http://www.transitionalcare.org/the-bridge-model/
- Re-Engineered Discharge Program – Project RED
  - https://www.bu.edu/fammed/projectred/
- Guided Care
  - http://www.guidedcare.org/

KEY COMPONENTS OF TRANSITIONAL NURSING CARE

- Screening – target patients at high risk for poor outcomes
- Relationship building – foster relationships between patients, caregivers and providers
- Engaging patients and caregivers – develop collaborative care plans that honor patient's preferences, values and goals
- Assessing and managing symptoms and risk factors – identify and address patient's priority risk factors and symptoms
- Promoting self management of chronic conditions – educate to prepare patients to recognize yellow and red zone danger signals and take appropriate actions; encourage patients to embrace lifestyle changes; promote medication management
- Promoting continuity – foster communication between health care settings
- Coordinating care – promote follow up care and connections to needed health care and community resources

SCREENING CRITERIA AND RISK ASSESSMENT

Are the following statements true for the patient?

- ❑ Documented primary or secondary diagnosis of Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI), an/or Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Lives within 30 miles of the discharging facility
- ❑ Not referred to Hospice
- ❑ Does not pose a risk to in home care provider

If yes to all on previous slide, must have one asterisked or two or more of the following risk factors:

- ❑ *** PRIMARY DIAGNOSIS OF HEART FAILURE or COPD**
- ❑ *** HOSPITALIZATIONS WITHIN THE LAST 30-DAYS**
- ❑ *** ISSUES WITH MEDICATION OR TREATMENT ADHERENCE**
- ❑ Poly pharmacy (6 or more medications)
- ❑ Two or more hospitalizations in the last 6 months
- ❑ Inadequate support system
- ❑ Age 80 or older
- ❑ Moderate to severe functional deficits (subjective assessment)
- ❑ Three or more comorbidities

OUTLINE OF A TRANSITIONAL CARE INTERVENTION

- Meet the patient at the bedside to introduce the program
- Communicate with inpatient team and participate in discharge plan
- Visit/assess patient in home within 3 days of discharge
- Coordinate needed care
- Attend medical office visits and participate in plan of care
- See patient in person or talk with patient by phone once weekly over a course of 30-60 days
- Graduate patient from program

COMPREHENSIVE IN HOME VISIT

- Physical
  - Symptom assessment pertinent to reason for hospitalization and chronic conditions
  - Vital signs Focused Nursing/system assessment Education
- Psychosocial
  - Support system Barriers to care Depression/anxiety Advanced directives
- Medications
  - Reconciliation Management/organization Adherence Education
- Discharge instructions /follow up care
  - Appointments Diagnostics Instructions/self-care Education
- Nutrition/diet habits
  - 24 hour recall Knowledge of therapeutic diet(s) Education
- Functional status
  - Home safety ADLs/IADLs Assistive devices Education
- Goals and action plans

PRIMARY CAUSES OF READMISSION

- Gaps in care – premature discharge or timing of discharge, continuity of care
- Health condition/Change in status – high risk diagnoses/co-morbidities, pt lack of awareness/whom to contact
- Medications – barriers to adherence, errors
- Health care coverage – Medicare highest risk factor, self pay, Medicaid
- Plan of care - lack of goals of care discussions, pt unable to keep appointments
- Demographics and psychographics – race, gender, age, income
- Patient engagement – readiness to discharge, understanding of self care, understanding of follow up plan, connection/relationship with outpatient providers

Transitions of Care often boils down to Maslow's Hierarchy!

Patients need a place to live, food, safety and security before you can address other barriers.

If a patient has to choose between food and medication refills…

If a patient is "non-compliant" with their prescribe low sodium diet but they only get meals-on-wheels…

If a patient is the primary caregiver for a disabled spouse…

If a patient lives at the shelter…

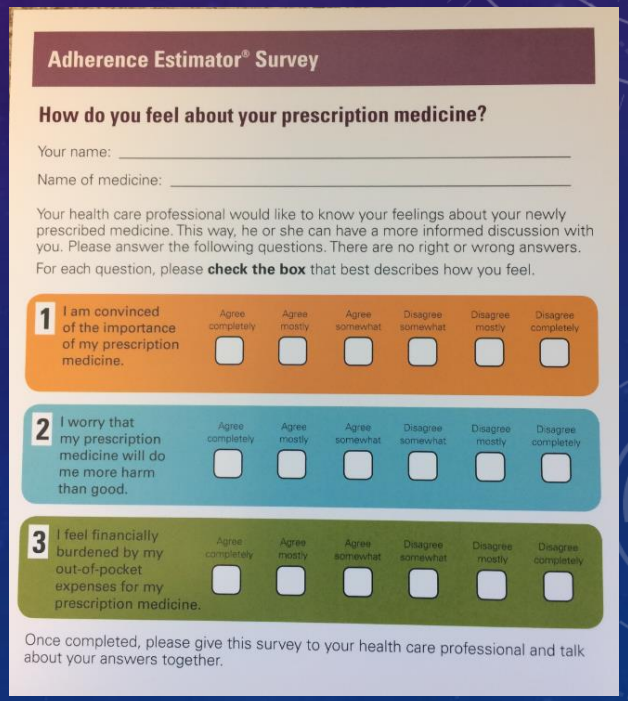
If a patient has untreated depression…

If a patient is being taken advantage of by one of their children…

MEDICATION ADHERENCE

3 primary causes of medication non-adherence:

1. Knowledge deficits related to the purpose and importance
    - Assess knowledge
    - Address knowledge deficits
2. Concern about side effects
    - Educate about purpose and SEs
    - Weigh benefit vs risk
    - Encourage discussion with provider
3. Financial burden - Utilize resources to identify lower cost options
    - Insurance company formularies
    - Low cost clinics
    - Pharmaceutical programs - http://www.needymeds.org/
    - Other - ttps://www.pparx.org/prescription_assistance_programs



Adherence Estimator® Survey

How do you feel about your prescription medicine?

Your name: _____

Name of medicine: _____

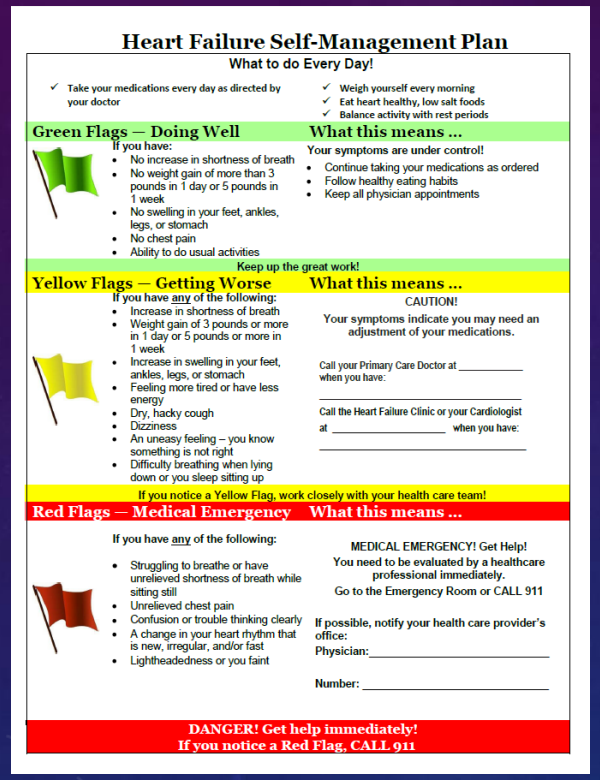
Your health care professional would like to know your feelings about your newly prescribed medicine. This way, he or she can have a more informed discussion with you. Please answer the following questions. There are no right or wrong answers.

For each question, please **check the box** that best describes how you feel.

		Agree completely	Agree mostly	Agree somewhat	Disagree somewhat	Disagree mostly	Disagree completely
1	I am convinced of the importance of my prescription medicine.	☐	☐	☐	☐	☐	☐
2	I worry that my prescription medicine will do me more harm than good.	☐	☐	☐	☐	☐	☐
3	I feel financially burdened by my out-of-pocket expenses for my prescription medicine.	☐	☐	☐	☐	☐	☐

Once completed, please give this survey to your health care professional and talk about your answers together.

PATIENT ENGAGEMENT/SELF MANAGEMENT



Heart Failure Self-Management Plan

What to do Every Day!

- ✓ Take your medications every day as directed by your doctor
- ✓ Weigh yourself every morning
- ✓ Eat heart healthy, low salt foods
- ✓ Balance activity with rest periods

Green Flags — Doing Well | **What this means ...**

If you have:
- No increase in shortness of breath
- No weight gain of more than 3 pounds in 1 day or 5 pounds in 1 week
- No swelling in your feet, ankles, legs, or stomach
- No chest pain
- Ability to do usual activities

Your symptoms are under control!
- Continue taking your medications as ordered
- Follow healthy eating habits
- Keep all physician appointments

Keep up the great work!

Yellow Flags — Getting Worse | **What this means ...**

If you have any of the following:
- Increase in shortness of breath
- Weight gain of 3 pounds or more in 1 day or 5 pounds or more in 1 week
- Increase in swelling in your feet, ankles, legs, or stomach
- Feeling more tired or have less energy
- Dry, hacky cough
- Dizziness
- An uneasy feeling – you know something is not right
- Difficulty breathing when lying down or you sleep sitting up

CAUTION!
Your symptoms indicate you may need an adjustment of your medications.

Call your Primary Care Doctor at _____ when you have:
_____

Call the Heart Failure Clinic or your Cardiologist at _____ when you have:
_____

If you notice a Yellow Flag, work closely with your health care team!

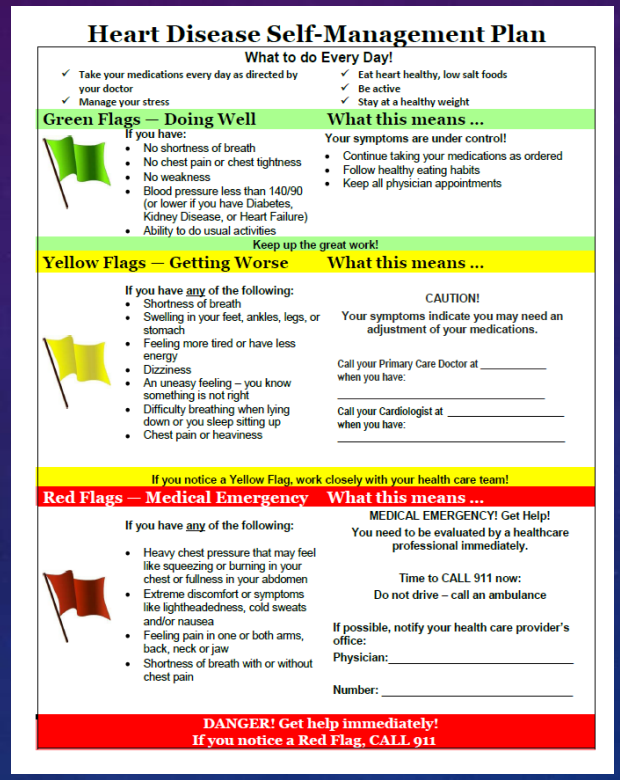
Red Flags — Medical Emergency | **What this means ...**

If you have any of the following:
- Struggling to breathe or have unrelieved shortness of breath while sitting still
- Unrelieved chest pain
- Confusion or trouble thinking clearly
- A change in your heart rhythm that is new, irregular, and/or fast
- Lightheadedness or you faint

MEDICAL EMERGENCY! Get Help!
You need to be evaluated by a healthcare professional immediately.
Go to the Emergency Room or CALL 911

If possible, notify your health care provider's office:
Physician:_____
Number: _____

DANGER! Get help immediately!
If you notice a Red Flag, CALL 911



Heart Disease Self-Management Plan

What to do Every Day!

- ✓ Take your medications every day as directed by your doctor
- ✓ Manage your stress
- ✓ Eat heart healthy, low salt foods
- ✓ Be active
- ✓ Stay at a healthy weight

Green Flags — Doing Well | **What this means ...**

If you have:
- No shortness of breath
- No chest pain or chest tightness
- No weakness
- Blood pressure less than 140/90 (or lower if you have Diabetes, Kidney Disease, or Heart Failure)
- Ability to do usual activities

Your symptoms are under control!
- Continue taking your medications as ordered
- Follow healthy eating habits
- Keep all physician appointments

Keep up the great work!

Yellow Flags — Getting Worse | **What this means ...**

If you have any of the following:
- Shortness of breath
- Swelling in your feet, ankles, legs, or stomach
- Feeling more tired or have less energy
- Dizziness
- An uneasy feeling – you know something is not right
- Difficulty breathing when lying down or you sleep sitting up
- Chest pain or heaviness

CAUTION!
Your symptoms indicate you may need an adjustment of your medications.

Call your Primary Care Doctor at _____ when you have:
_____

Call your Cardiologist at _____ when you have:
_____

If you notice a Yellow Flag, work closely with your health care team!

Red Flags — Medical Emergency | **What this means ...**

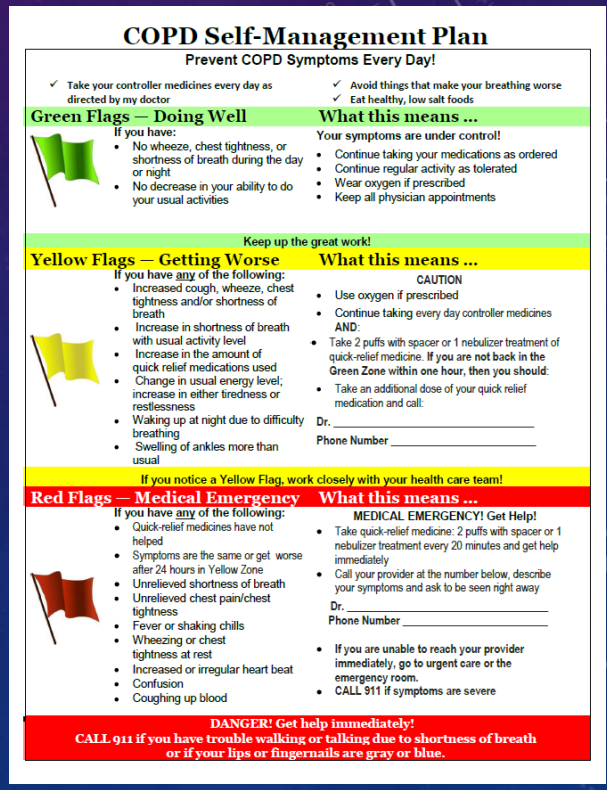
If you have any of the following:
- Heavy chest pressure that may feel like squeezing or burning in your chest or fullness in your abdomen
- Extreme discomfort or symptoms like lightheadedness, cold sweats and/or nausea
- Feeling pain in one or both arms, back, neck or jaw
- Shortness of breath with or without chest pain

MEDICAL EMERGENCY! Get Help!
You need to be evaluated by a healthcare professional immediately.

Time to CALL 911 now:
Do not drive – call an ambulance

If possible, notify your health care provider's office:
Physician:_____
Number: _____

DANGER! Get help immediately!
If you notice a Red Flag, CALL 911



COPD Self-Management Plan

Prevent COPD Symptoms Every Day!

- ✓ Take your controller medicines every day as directed by my doctor
- ✓ Avoid things that make your breathing worse
- ✓ Eat healthy, low salt foods

Green Flags — Doing Well | **What this means ...**

If you have:
- No wheeze, chest tightness, or shortness of breath during the day or night
- No decrease in your ability to do your usual activities

Your symptoms are under control!
- Continue taking your medications as ordered
- Continue regular activity as tolerated
- Wear oxygen if prescribed
- Keep all physician appointments

Keep up the great work!

Yellow Flags — Getting Worse | **What this means ...**

If you have any of the following:
- Increased cough, wheeze, chest tightness and/or shortness of breath
- Increase in shortness of breath with usual activity level
- Increase in the amount of quick relief medications used
- Change in usual energy level; increase in either tiredness or restlessness
- Waking up at night due to difficulty breathing
- Swelling of ankles more than usual

CAUTION
- Use oxygen if prescribed
- Continue taking every day controller medicines **AND**:
- Take 2 puffs with spacer or 1 nebulizer treatment of quick-relief medicine. **If you are not back in the Green Zone within one hour, then you should:**
- Take an additional dose of your quick relief medication and call:

Dr. _____
Phone Number _____

If you notice a Yellow Flag, work closely with your health care team!

Red Flags — Medical Emergency | **What this means ...**

If you have any of the following:
- Quick-relief medicines have not helped
- Symptoms are the same or get worse after 24 hours in Yellow Zone
- Unrelieved shortness of breath
- Unrelieved chest pain/chest tightness
- Fever or shaking chills
- Wheezing or chest tightness at rest
- Increased or irregular heart beat
- Confusion
- Coughing up blood

MEDICAL EMERGENCY! Get Help!
- Take quick-relief medicine: 2 puffs with spacer or 1 nebulizer treatment every 20 minutes and get help immediately
- Call your provider at the number below, describe your symptoms and ask to be seen right away

Dr. _____
Phone Number _____

- **If you are unable to reach your provider immediately, go to urgent care or the emergency room.**
- **CALL 911 if symptoms are severe**

DANGER! Get help immediately!
CALL 911 if you have trouble walking or talking due to shortness of breath or if your lips or fingernails are gray or blue.

PATIENT ENGAGEMENT/MOTIVATIONAL INTERVIEWING

What is Motivational Interviewing? "…a collaborative, person-centered form of guiding to elicit and strengthen motivation for change." Braastad, J.

- The spirit of MI can be translated into five central principles summarized by the acronym DEARS:

  - **D**evelop discrepancy
  - **E**xpress empathy
  - **A**mplify ambivalence
  - **R**oll with resistance
  - **S**upport self-efficacy

OPEN ENDED QUESTIONS – MASTER IT!

Examples to use with chronic disease patients:

- What is most important to you right now concerning your health?
- What are you currently doing to care for your _____?
- What does having _____ mean to you?
- What are the most important components in caring for your _____?
- Which behavior is particularly challenging?
- Which behavior would you like to work on?
- Which behavior would you be most successful changing?

SMART GOALS/ACTION PLANS

- Specific
- Measurable
- Attainable
- Relevant
- Time bound

In writing your action plan, be sure it includes:

1. What are you going to do?
2. How much are you going to do?
3. When are you going to do it?
4. How many days a week are you going to do it?

Example**: This week I will walk (what) around the block 3 times (how much) before lunch (when)3 times this week (how many)**

How confident are you? (0 = not at all confident; 10 = totally confident) _____

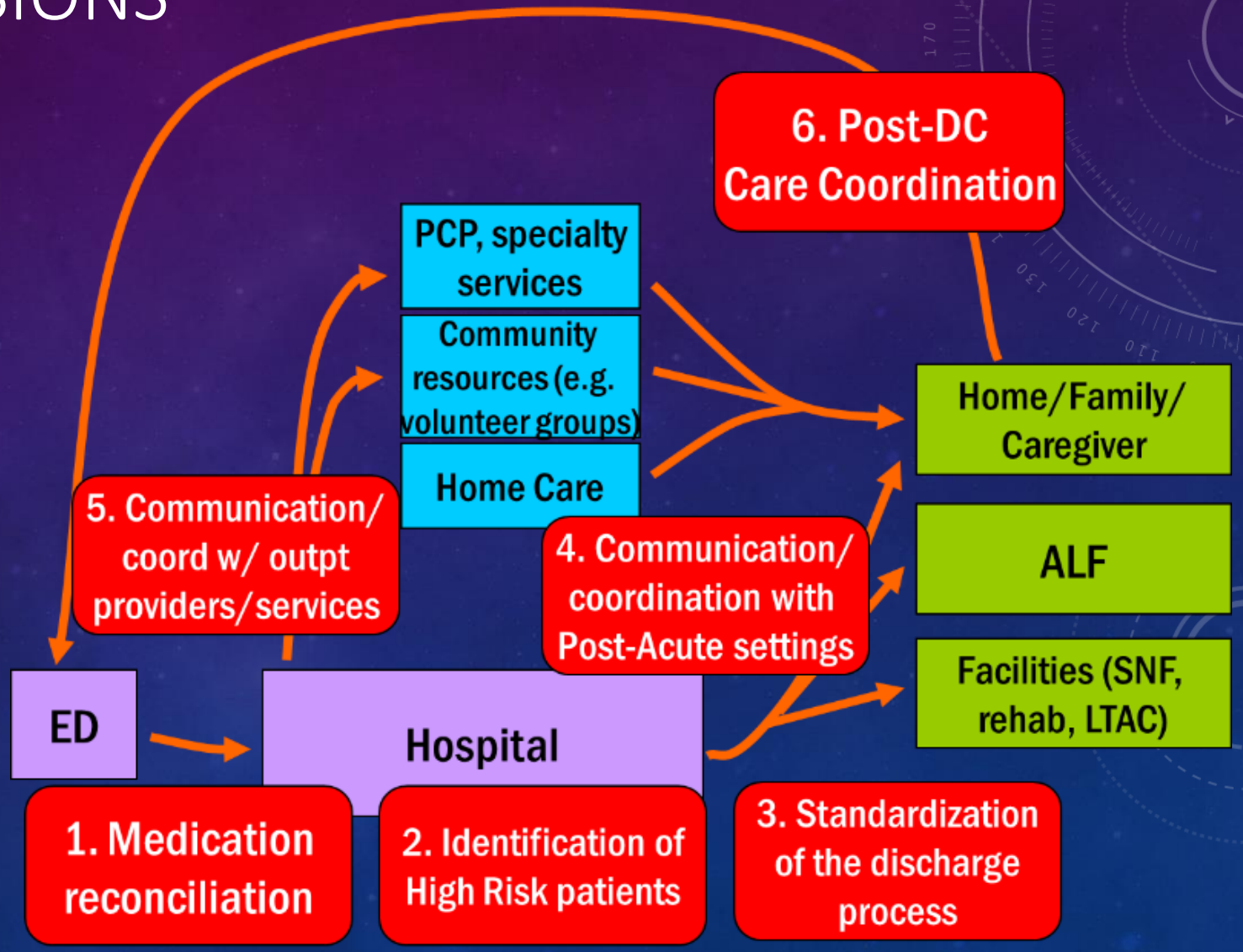
PUTTING IT INTO PRACTICE!

A glimpse at a patient's journey:

53 y/o male referred to the Care Transition Program during hospital admission - dx acute decompensated systolic heart failure, ejection fraction 25%

Delving in – Face sheet, chart review, discharge summary, review of diagnostics, outpatient care review

DRIVERS OF READMISSIONS



The Face of Heart Failure

- 58 Year old male
- Coronary Artery Disease
- Diastolic dysfunction, Heart Failure Preserved Ejection Fraction with RV dysfunction
- Obstructive Sleep Apnea
- COPD (chronic obstructive pulmonary disease)
- Diabetes Mellitus
- Obstructive Nephropathy
- Chronic Kidney Disease, stage III
- Morbid Obesity
- Chest Pain
- Unspecified Depressive Disorder
- Unspecified Anxiety Disorder
- 34 prescribed medications on his medical record

Care Coordination Works…..
But it takes a LOT of work!

Touch Point	2015	2016 -
Emergency Dept	2	1
Hospital Admissions	8(17)	3
Office Visits	45	36
Phone Calls	104	80
Care Coordination	19	65
Health Care Cost	$755,725	$256,367

Over the two year period this patient saw 54 different providers (MD, APP, RN, LCSW, LMSW, RT, PT, DPM, OT)

“Never ever depend on governments and institutions to solve any major problems. All social change comes from the passion of individuals.” Margaret Mead

Questions

Comments

REFERENCES

- National Transitions of Care Coalition, http://www.ntocc.org/
- Transitional Care Can Reduce Hospital Readmissions, April 2015 Vol. 10 No. 4Author: Joan M. Nelson, DNP, ANP-BC, and Amy L. Pulley, BA, https://www.americannursetoday.com/transitional-care-can-reduce-hospital-readmissions/
- Suggested Model for Transitional Care Planning, https://www.health.ny.gov/professionals/patients/discharge_planning/discharge_transition.htm
- Readmissions Reduction Program (HRRP), https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html
- Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services, https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf
- Transitional Care Management Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- Episode Payment Models: General Information, https://innovation.cms.gov/initiatives/epm
- Braastad, J. (n.d.). Using motivational interviewing techniques in SMART recovery. SMART Recovery: Get Smart FAST Distance Training Program
- Reducing Hospital Readmissions by Addressing the Causes, http://www.medicareadvocacy.org/reducing-hospital-readmissions-by-addressing-the-causes/